Improving Health Care Access for the Uninsured and Underinsured

A Report presented to the
Dakota County Board of Commissioners

by the Human Services Advisory Committee

November 2004

Dakota County Community Services
1 Mendota Road, Suite 500
West St. Paul, MN 55118
651 554-5742

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Executive Summary

The Human Services Advisory Committee (HSAC) advises the Dakota County Board of Commissioners on issues likely to impact how it delivers community services. HSAC uses its monthly meetings to consult with experts and to develop a citizen view of the county role on whatever topic is under study. This HSAC study focused on answering one primary question: What should be done to address the issue of health care access for uninsured/underinsured residents in Dakota County?

Background:

- It is estimated by the Minnesota Department of Health that there are 17,000 uninsured/underinsured residents in Dakota County. While some services are available, these services are not adequate to meet the need.
- Access to health care is directly related to income status.
- Lack of access to health care has negative impacts on individuals/families (lack of access to regular primary/preventive care; exacerbation of chronic health conditions; higher mortality rates; inappropriate use of emergency rooms and emotional and psychological toll).
- Lack of access to health care also has negative impacts on the community (increased costs; increased participation in public programs; increased taxes & cost of health care premiums; lost wages and productivity; increased risk of communicable disease; inappropriate use of health care delivery systems, i.e. emergency rooms).

HSAC consulted with key informants from the health care access field including staff from Park Nicollet Clinic, Community Action Council, Fairview Ridges Hospital, Southside Community Health Services, Westside Health Center and St. Mary's Health Care Center.

HSAC believes that there is a role for Dakota County in helping to improve access to health care for the uninsured and underinsured. HSAC offers recommendations for county action including:

Main recommendation - Create a Health Care Access Advisory Group to look at how to best develop options studied by HSAC, convening interested stakeholders in early 2005 with the Public Health Department taking the leadership role in facilitating this group. Other recommendations follow.

- Improve the utilization of public programs
  - Ensure that all Dakota County residents eligible are enrolled in public health care programs (such as Medical Assistance, Minnesota Care and General Assistance Medical Care)
  - Implement a public education campaign to educate all County residents on available health care service/insurance options
  - Build County awareness of issue and develop next steps based on Board priorities; enhance information/referral consistency across County departments

- Expand Availability of low-cost health care providers
  - Develop a coordinated strategy to work with low-cost health care providers to expand services in the County; develop a consortium/brokers provider network for low cost providers or increase low cost providers in the county

- Assess feasibility for County based initiatives:
  - Develop a 24-hour Information/help line to assess need and refer for services
  - Develop "Mobile Health Van" to increase outreach services; seek grant funding

- Promote policy changes: simplify Medical Assistance forms
  - Allow emergency rooms to post/inform low cost provider information
  - Allow individual tax credits
  - Establish a volunteer bank – citizen help in exchange for health care voucher.

I. Background information

a. HSAC Study Process

The key study question for the study was: "What should be done to address the issue of health care access for uninsured/underinsured residents in Dakota County?" Answering this question guided the process and results of the HSAC as it examined this important public policy issue.

The 2004 HSAC study process included:

March	Barriers to access
	Current services – County
April	Ask the experts – Community Low-Cost Systems
May	Ask the experts – Community Low-Cost Providers
June	Systems Options/What's Available
July-August	Conclusions & Recommendations

HSAC's study process had the goal of describing issues, barriers, options and resources available to promote health care access for the uninsured and underinsured. Sources of information included:

- federal, state and local data and reports;
- studies by state and national organizations;
- interviews with health care organizations

The results of this process, based upon reviewing information from a wide variety of sources as well as the personal views of HSAC members, are presented in this report.

The "Background" section of the report includes these elements:

- What's the problem? (a brief description of the overall issues with health care access for the uninsured and underinsured)
- A list of strong predictors of access to quality health care
- A list of health care access barriers
- Estimates/Description of Uninsured - national, state and County
- Case examples showing eligibility limits for public health programs for single persons and families
- Examples of why County residents do not have insurance
- Impacts of no insurance on individuals and communities
- Current services available
- Health care spending by public and private sectors, breakdown in subcategories for major public programs.

b. Description of the Problem of Uninsured/Underinsured

- **What's the Problem?** The first part of the process was intended to answer the question "What's the problem?". HSAC identified the following general descriptors of health care not being available.

  - Increasing number of uninsured/underinsured
  - Negative impact on individuals/families
  - Lack of access to primary care services
  - Risk of severe illness and death
  - Negative impact on the community
  - Inappropriate use of health care system
  - Increased cost burden

- **Predictors of Access** - Next HSAC developed a list of strong predictors of access to quality health care. These included having:

  - Health insurance
  - A higher income level
  - Regular primary care provider or other source of ongoing health care

- **Barriers** - On the other hand, health care access barriers were found to include:

  - No/poor/inadequate insurance coverage
    - funding and reimbursement reductions
    - state/local policy changes
    - premiums rising
  - Lack of accessible & affordable care services
    - primary health care
    - specialty services
  - Ancillary/Support barriers
    - Personal barriers (cultural, language)
    - Transportation

- **Estimates/Description of Uninsured** - HSAC reviewed data from the Minnesota Department of Health and the U.S. Department of Health and Human Services. As a result, estimates of the numbers of uninsured at the national, state and County levels was determined. During the recent past, there have been increasing numbers of uninsured/underinsured at the national, state and County levels:

  USA - 41 to 44 million from 2001 to 2002
  - USA estimate of uninsured is probably seriously under-reported, perhaps by as much as 50%

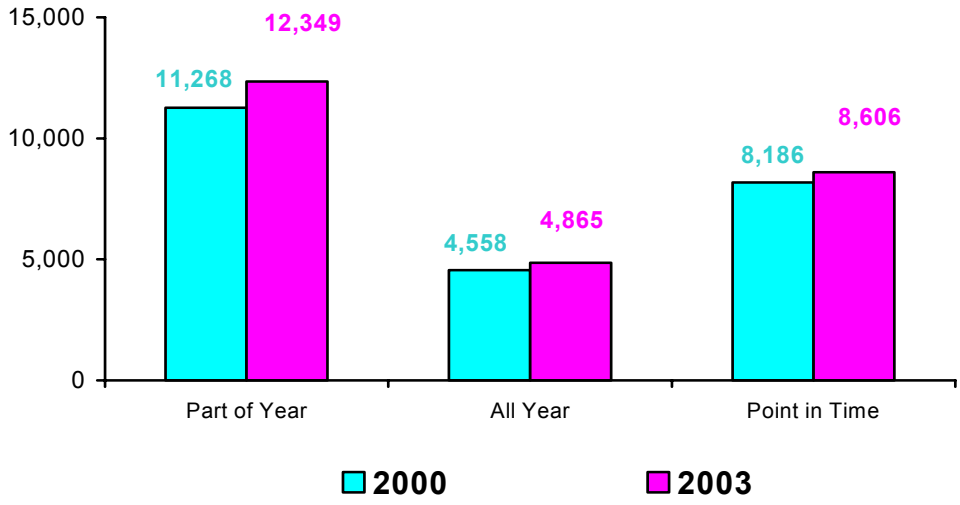
  Minnesota - Lowest # of uninsured in nation
  - 266,000 to 458,000 in 2001

  Dakota County - 17,000 uninsured in 2003 (Dakota County source: Minnesota Department of Health, Health Economics Program)

Uninsured rates are noticeably higher for minority populations, rates are as high as 40% for some minority populations. Of the 45 million people without health insurance in this country, nearly 70 percent are working full time or are the dependents of those workers. (New York Times, 10/26/04)

Chart 1, below, compares the estimated number of uninsured residents of Dakota County between the years 2000 and 2003. By adding the 12,349 in the 2003 "part of year" bar to the 4,865 in the "all year" bar, this totals 17,214.

Chart 1
Estimated Number of Uninsured Residents
Dakota County
2000-2003



Also at the Dakota County level, there has been a growth in applications to the Employment and Economic Assistance Department. Individual participation in all public assistance programs has increased by over 13% in 2003 over 2002 and by 51% over 2000. The 11% increase in cases in 2003 was mostly a result of medical program changes that increased participation. The number of cases in 2003 is 37% greater than in 2000. Over 90% of all cases have a medical component, showing its importance in helping to meet citizens' basic needs.

In terms of demographics, what general statements can be made about who are the uninsured in Dakota County?

- By gender, more males are uninsured all year; more females are uninsured part of year
- By age – 18 to 64 year olds have the greatest levels of being uninsured (greatest number among 18 to 34 year olds)
- By income - the greatest number of uninsured are among people below 200% poverty
- By race/ethnicity – the greatest number of uninsured are in populations of color

Below is a summary of some of the information about health care access obtained from a variety of sources.

- In 1997 42% of the uninsured children were eligible for Medicaid but not enrolled. From Kaiser Family Foundation (Oct 1998)

- Centers for Disease Control found that in 2003, 2.6 million more people ages 18-64 were uninsured for more than a year, raising the total to 24.5 million. Research has documented erosions in both the quality and the continuity of coverage.

- A new study form the Center for Studying Health System Change showed that medical debt is a problem for nearly 20 million American families. As found in the Commonwealth Fund Biennial Health Insurance Survey (released March 2004): 71 million working-age adults in this country are experiencing problems paying medical bills or are paying off accrued medical debt. Of those, 44% said they used all or most of their savings on medical bills, and 20% had large credit care debt or took a loan out against their home to pay medical bills.

- From Health Care Coverage in America prepared by Alliance for Health Reform with a Robert Wood Johnson Foundation (RWJ) grant, National Academy of Sciences' Institute of Medicine (IOM) - People without health insurance often go without care/delay care. The care they do receives is likely to be of lower quality that care to insured people and they may be charged more for it. An estimated 18,000 adults die each year because they are uninsured and can't get appropriate care according to the IOM.

- Also in this RWJ: Hispanics are far more likely than any other rethink group to be uninsured. In 2002, 32.4% were uninsured for the entire year, compared to 20.2 % of blacks, 18.4% of Asian/Pacific Islanders, and 10.7% of non-Hispanic whites. …Hispanic immigrants who have been in the US for less than 5 years, 72% are uninsured.

- A Commonwealth Fund study found that the # of uninsured, low income children would decline by nearly 40% and the # of uninsured adults would decline by more than 25% if every person with public/private insurance at the beginning of a given year retained it through the next 12 months.

- **Limits on eligibility** - HSAC discovered that there are several publicly sponsored health care programs but that there are limits to who is eligible for these programs. Examples of problems in qualifying as eligible for publicly funded health care programs are found in the case examples below. Families can be low income and still not be eligible for public health care programs. Examples include:

Single adult age 30, working full-time receiving $10.00/hr. Gross income is $400/wk or $1,600 per month. Income standard is $582/mo. (Gross income must be below this to qualify for GAMC). Income standard to receive MinnesotaCare is $1,358/mo. This person would not be eligible for any of the MN Healthcare programs. (Not even hospital coverage should he become hospitalized.)

Family of 4 Two parents and two children ages 11 and 13. Both parents work full-time and earn $10.00/hr. Gross income is $800/wk or $3,200 per month. After allowing for some disregards to the income, the countable net income for the children is $3,020. The standard for a HH of 4 for children between the ages of 2-18 is $2,358. So the kids would not be eligible for MA. After allowing for some disregards to the income, the countable net income for the parents is $2,656. The standard for a HH of 4 for parents is $1,571. So the parents would not be eligible for MA. If no insurance is available through the parent's employers the family may qualify for MinnesotaCare with a monthly premium of $221.

- **Why no insurance?** - Why do Dakota County residents have no health insurance? HSAC discovered a variety of reasons including:

- Rising cost of health insurance premiums
- Slowed economy – higher unemployment rates
- Changes in employer-sponsored coverage
- Complexity of public insurance programs
- Personal barriers – spending on basic needs (food, clothing, shelter)

Concerning the rising cost of health insurance premiums, the average annual health care premiums in 2004 (Source: Kaiser Family Foundation)

Single: Total - $3,695; Employee portion - $3,137; Employee portion - $558
Family: Total - $9,950; Employee portion - $7289; Employee portion - $2,261

There has been a growth in the employed but the unemployed rate has risen at the same time. Here are the total employment figures for Dakota County:

Year	Employment	Year	Employment
1999	147,497	2002	159,749
2000	153,375	2003	164,503
2001	155,703		

Thus, the total change from 1999-03 as an increase of 17,006 jobs. However, the unemployment rate for Dakota County in 2000 was 2.2%, for 2001 2.8%, for 2002 3.7%, for 2003 4.2%; 2004 through August about 4.1% Thus, there are more jobs in total but the unemployment rate has also risen, nearly doubling in the last four years. The unemployed are far more likely to be uninsured.

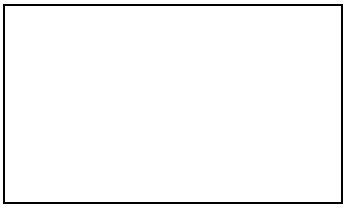
The Minnesota Chamber of Commerce members reported in a recent survey that 51% of members say they have fewer choices for health care coverage than they did a few years ago and 70% say that their costs are higher with 16% of that group saying they are likely to stop providing coverage as an employee benefit if costs continue to rise. (Source: Minnesota Physicians MEDFAX newsletter, October 4, 2004)

- **Impacts on Individuals and Communities** - What is impact of a lack of access to health care, both individuals and communities?

The negative impact on individuals and families includes:

- Lack of access to regular primary/preventive care
- Exacerbation of chronic health conditions
- Higher mortality rates
- Inappropriate use of emergency room
- Emotional and psychological toll

One example of how problems with access to health care affects a family is in the newspaper article which follows.



NEWS ARTICLE: "For couple, one choice: do without"

Shira Kantor, Star Tribune, October 6, 2004 (excerpted)

This week is a frightening one for Fred and Cheryl Walker of Burnsville. It is the first week that the couple, both disabled and unemployed, must do without health insurance. Before their insurance ran out last week, the Walkers filled prescriptions for the 19 medicines they take between them. They say they will figure out their next steps in a month, when their medicine supply needs to be renewed. "Both of us are very, very scared," Cheryl Walker said. "It's just really hitting us hard." The rush of people like the Walkers seeking help in Dakota County for lack of health insurance "is constant," said Mary Ajax, president of the nonprofit Community Action Council. "Probably every day we're talking to families who need health care and don't know where to turn." "Health insurance has gotten so expensive that [many families] don't have any choice" but to go without it, Ajax said. "They are trying to keep a roof over their heads and food on their table and they're just taking their chances," she said." Sue Krey, a

community services program supervisor for Dakota County, said the number of people seeking health care aid from the county has jumped by 52 percent in the past four years. In August 2000, 8,141 people were receiving medical assistance; by August 2004, that number rose to 12,410, Krey said. Fred Walker, 55, was working as a software engineer in Chaska when he was laid off a year and a half ago, shortly after he'd had two surgeries, a stroke and a heart attack. His health problems left him in a wheelchair most of the time, unable to work. Walker's health insurance plan was extended after the layoff -- at a cost to the Walkers of $900 a month, plus co-payments for their medicine and office visits. But the coverage expired after 18 months, at the end of September. The couple's only income is the disability check Fred Walker collects each month, $4,000 before taxes. With a $1,300 monthly mortgage payment and other expenses, the Walkers are worried that they won't have enough left over to cover the cost of their prescription drugs. Fred Walker's heart problems are compounded by the fact that he is diabetic and has only 25 percent of his kidney function. He has been undergoing kidney function tests and receiving shots to boost his iron level every other week. That costs $1,400 each time, but with insurance, it cost the Walkers a small co pay. Fred Walker said he thinks he could afford an insurance policy, but that he can't get anyone to insure him because of his health problems. "I will let my stuff slide," Cheryl Walker said. "He won't want me to, but I will." One of her five prescriptions, Celebrex, for arthritis, costs $187 a month, she said. With the loss of their health insurance, the couple also lost their life insurance policy, an added worry for Cheryl Walker. In a letter to the editor, Cheryl Walker worried aloud that the couple, both in their mid 50s, could lose their home, in the 3400 block of E. 126th St., if they can't pay their medical bills. "Something has got to be done," she wrote. "This is urgent for many Americans like myself."

HSAC also identified negative impacts on communities due to a lack of access to health care, these include:

- Increased costs
- Increase participation in public programs
- Increased taxes & cost of health care premium
- Lost wages and productivity
- Increased risk of communicable disease
- Inappropriate use of health care delivery systems, i.e. emergency rooms

c. ***Current health care for uninsured/underinsured***

The major publicly-sponsored health care programs are:

- Medical Assistance
- Medicare
- Minnesota Care
- General Assistance Medical Care
- COBRA

Following is a brief description of these programs. The first four of these programs are administered in Dakota County by the Employment and Economic Assistance Department.

Medicare - The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). New prescription drug program will limit the drug formulary resulting in some persons, including those with mental illness, having fewer drug options.

Medical Assistance - Children under the age of 21, parents or relative caretakers of dependent children, pregnant women, people who are 65 or older and people who have a disability. Income limits vary depending on family size, age and whether someone is pregnant, blind or has a disability. Most enrollees can only have a limited number of assets. There is no asset limit for pregnant women and children under age 21.

Minnesota Care - Minnesota residents who do not have access to affordable health insurance. If you are an adult and do not have children living with you, or if your children are over age 21, you must have lived in Minnesota for six months. There are several requirements to qualify including, persons must not have other health insurance now or have had health insurance (including Medicare), for at least four months except for Medical Assistance enrollees whose health insurance premium was paid for by Medical Assistance, not be able to get health insurance through an employer who offers to pay at least half the monthly cost.

General Assistance Medical Care - Low-income adults, ages 21-64, who have no dependent children under age 18 and who do not qualify for federal health care programs. Income limits vary depending on family size and benefit level. The asset limit is $1,000 for comprehensive coverage. The asset limit for hospitalization only coverage is $10,000 for one and $20,000 for two or more

COBRA - Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA gives certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances.

In addition, the Dakota County Public Health Department provides a variety of services at the local level, including a broad range of health services to individuals, families and communities to prevent illness and disease. The department fosters a partnership with many organizations and community groups to address and resolve health issues and concerns. The focus is on child health, family health, and home health care.

Examples of local private healthcare partnerships are listed immediately below and explained in greater detail following:

Non-Profit:

Park Nicollet Clinic
Community Action Council
Fairview Ridges Hospital
Wakota Life Care Center
East Metro Family Practice

Charity care

St. Mary's and variety of specialty care providers

Park Nicollet Clinic: Park Nicollet Clinic has extensive listing in Dakota County. Park Nicollet collaborates with community organizations including Community Action Council and Fairview Ridges Hospital to increase access and provide medical services to the uninsured/underinsured.

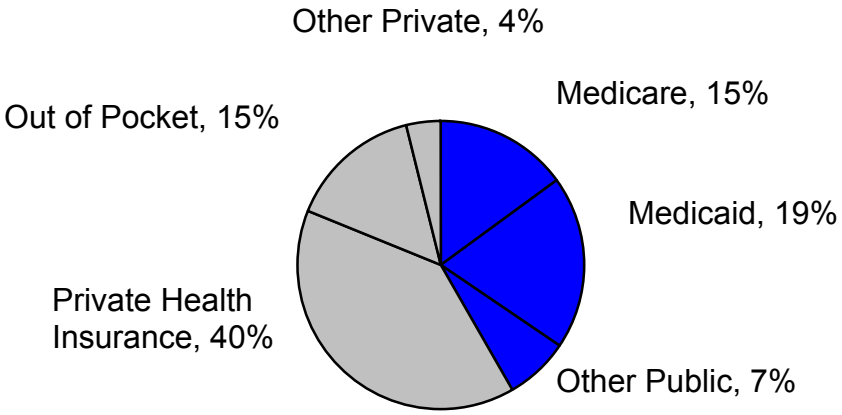
Community Action Council: CAC's services are community-based so that families and/or individuals can access services in convenient, accessible locations. CAC operates more than 48 neighborhood sites in Dakota County and has 7 bilingual staff and 3 Spanish-speaking volunteers. CAC served 1,100 people in 2003, of which approximately 16% needed help accessing or obtaining medical services. CAC helps to: Screen people to assess their needs for medical insurance, Provide accurate information, Arrange for emergency appointments, etc..

Fairview Ridges Hospital – Fairview's mission is to improve the health of the communities they serve, regardless of insurance type and ability to pay. Fairview clinics accept all government insurances. Fairview's Charity Care Program is offered to uninsured/underinsured individuals after government options are exhausted. Services are provided on a sliding fee scale based on income. Fairview also provides assistance to patients in finding insurance coverage. Approximately $280,000 was provided in charity care for 2003. Most Account balance write-offs are done because of client's inability to pay for medical services. In 2003, $3.5 million was written off. Fairview Ridges Hospital has the highest "bad debt" rate of any Twin Cities hospital.

Wakota Life Care Center - non-profit organization that assists people facing unplanned pregnancies in Minnesota and northwestern Wisconsin. The Center also offers some non-emergency general medical services.

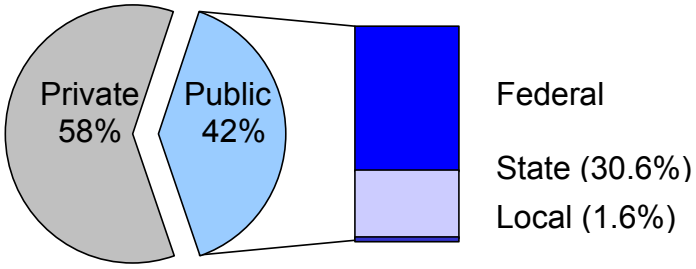
Minnesota health care spending in 2002 is shown on the charts below which include sources of revenue to pay for health care spending, public and private in the state.

Chart 2
Minnesota Health Care Spending in 2002: Where It Came From
(Total $22.8 Billion)



As seen in Chart 3, below, most of Minnesota's Public Sector Health Care Spending is Financed by the Federal Government.

Chart 3
Total Minnesota Health Expenditures in 2002:
$22.8 billion



Source Charts 2,3: MDH, Health Economics

II. Service delivery models

HSAC invited several health care providers and systems representatives to present information. The groups fell into two broad categories, 1) "Community Healthcare Centers/Providers" and 2) "Promising System Approaches".

Community Health Centers/Providers

Community Health Centers/Providers typically exist in areas where economic, geographic or cultural barriers limit access to primary health care services for a substantial portion of the population. These Centers traditionally tailor their services to the needs of the community. Many Centers have expanded services to the uninsured/underinsured by staying open during off-hours, such as evening, weekends and holidays, by providing language interpretation if necessary, as well as transportation, mobile outreach services and flexible payment plans. Family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities. Many of these Centers receive federal funding under the Public Health Service Act and are designated as federally qualified health centers (must be located in a medically underserved area, maintain a nonprofit status, etc.)

Community Health Centers – Examples which serve/wish to expand in Dakota County follow, including a brief explanation of who is served and how many Dakota County clients are seen:

Southside
- targets low income, uninsured
- primary care: medical, mental health, medications, dental
- 333 Dakota Co. citizens medical, 154 dental
- mix of public funding and patient fees

St. Mary's
- targets uninsured, 60% Latino
- episodic care, weekly free clinics
- 850 clients seen at Apple Valley site
- 100% volunteer staff, donated space

Westside
- targets low income
- primary care: medical, mental health
- 959 from IGH/SSP, 3300 other suburbs
- mix of public funding and patient fees

Southside and Westside are models the current federal administration is trying to build on with the potential for new federal funding of Federally Qualified Health Centers (FQHC).

Promising System Approaches

In an effort to look toward new or different models of providing access to health care for the uninsured and underinsured, HSAC looked at three promising approaches which have potential merit for development in Dakota County. Each of the three approaches is explained below.

Hennepin County Health and Community Initiatives Department

For Hennepin County – Assured Access – Individuals and families who meet financial screening guidelines. Hennepin County – Assured Access screens individuals and families for public health programs that they may qualify for such as MA or MN Care. Screening eligibility provides individuals and families with a verification card to present when they go to any sliding fee scale clinic. Gaps center around hospitalization care and pharmacy services. Individuals and families receive care at a discount from 25-100% based on their income in relation to the federal poverty guidelines. Hennepin County has an outreach program through the office of Multi-cultural services to address the health disparities among populations of color. The County provides outreach services to the uninsured at different locations within the County.

Portico Healthnet

Individuals and families who are uninsured. Must meet income guidelines. Individuals or households pay $25/month.Must live in Ramsey, Dakota or Washington County. Primary, preventive, specialty care, eye care prescriptions, outpatient mental health services and assistance with enrollment in public health care programs (MA, GAMC, MNCARE, etc.) Portico Healthnet – mission is to reduce the number of people without coverage for health care services. Since 1995, Portico Healthnet has helped more than 7,000 people connect to free or low-cost health coverage. Funding for Portico's health access program is provided by: Children's Hospitals and Clinics, Lakeview Hospital, Regions Hospital, HealthEast Care System and United Hospital (Allina). County could serve as a facilitator/convener.

American Project Access Network

This project links doctors to Federally Qualified Health Centers (FQFC) to provide on-demand specialty care to low-income individuals who do not have insurance, nor do they qualify for public assistance. Project Access is based on physicians volunteering their time to see patients for free, and other community partners, such as hospitals, donating the other medical services that patients need. Project Access originated in 1995 in Buncombe County (Asheville, North Carolina). There is no limit on how long a patient can be enrolled, the average enrollment is about six months. Patients are rescreened for eligibility on a 3 or 6 month basis. More than 50% of the patients become insured after 12 months.

III. Recommendations

HSAC believes that there is a role for Dakota County in helping to improve access to health care for the uninsured and underinsured. HSAC offers recommendations for county action including:

Main recommendation - **Create a Health Care Access Advisory Group** to look at how to best develop options studied by HSAC, convening interested stakeholders in early 2005 with the Public Health Department appointing the Advisory Committee members and taking the leadership role in facilitating this group. The Health Care Access Advisory Group would have oversight of developing the other recommendations, they would serve as a steering committee to make sure there is follow-up regarding the recommendations. The Advisory Group would report back to the County Board regarding their ongoing findings and recommendations.

The Advisory Group can keep track of changes at the state and federal levels, health care access issues are at the forefront of public discussion and can be expected to be so for some time. The Advisory Group can monitor changes and make suggestions for future County Board actions.

Other recommendations follow.

- **Improve the utilization of public programs**
  (See Appendix A for full version of short and long term options for this recommendation.)

Short Term:

- Improve the utilization of public programs
  Ensure that all Dakota County residents eligible are enrolled in public health care Programs (such as Medical Assistance, Minnesota Care and General Assistance Medical Care); Implement a public education campaign to educate all County residents on available health care service/insurance options; build County awareness of issue and develop next steps based on Board priorities; enhance information/referral consistency across County departments
- Implement Public Education Campaign – to educate all County residents on available health care service/insurance options.
- Build County awareness of issue and develop next steps based on Board priorities
- Enhance information/referral consistency across Community Services Departments

Long Term:

- Implement County Board approved new initiatives, within available resources
- Expand information/referral processes to all County Divisions/Departments
- Assure availability of coaching resources available to help yield competed application
- Establish system to validate level of poverty for providers

- **Expand Availability of Low-Cost Providers**
  (See Appendix A for full version of short and long term options for this recommendation.)

Short Term:

- Continue intake referral, health promotion, clinic coordination through Public Health
- Develop a coordinated strategy to work with low-cost health care providers to expand services in the County.

Long Term

- Implement New Initiatives as/if Board approved. Examples to be explored include:
  - Develop "Portico" type health care access "pilot" program.
  - Develop a consortium/brokers provider network for low cost providers +/or increase low cost providers in the county.

- **Assess feasibility for County based initiatives**

- Develop a 24-hour Information/help line to assess need and refer for services
- Develop "Mobile Health Van" to increase outreach services; seek grant funding

- **Promote Policy Changes - Examples to be explored include:**

- Simplify Medical Assistance forms
- Allow emergency rooms to post/inform low cost provider information
- Allow individual tax credits
- Allow individual tax form check off for contribution to County uninsured fund
- Establish a volunteer bank – citizen help in exchange for health care voucher
- Allow Providers get decreased property tax if provide "x" free/slide fee care
- Allow Small business buying pool
- Support Fed/state health access legislation and initiatives

	APPENDIX A: RECOMMENDATIONS FULL VERSION	
Recommendation Category	**Short-Term Options (6 to 12 months)**	**Long-Term Options (1 to 5 years)**
Improve Utilization of Public Programs	1. Educate County Board members of the need to address this issue. *Resources: Maximize Existing Resources* *Determine $$ sources to support new Initiatives* *Action Steps:* • *Conduct a Board Presentation to show urgency of need and gain support for addressing the problem* • *Determine next steps based on County Board feedback* 2. Enhance information/referral across Community Services Departments *Resources: Maximize Existing Resources* *Action Steps: Public Health Department will take leadership role* • *Convene a workgroup to:* ✓ *Assess and develop comprehensive directory of available health care service options* ✓ *Post info on County website, include website linkages, if possible* ✓ *Post info in County Departments/Lobbies using appropriate language – DHS may have available informational materials* ✓ *Ensure info resources for those who are not eligible for Public Health programs* ✓ *Ensure staff training* 3. Implement Public Education Campaign – to educate all County residents on available health care service/insurance options. *Resources: Maximize Existing Resources* *Action Steps: Public Health Department will take leadership role* • *Partner with community stakeholders to coordinate public education processes – for example: posting info, public service announcements, newspaper articles, etc.*	1. Implement County Board approved new initiatives. Examples of new Initiatives: Develop outreach centers, hire an outreach coordinator, create health care service models based on Portico, Hennepin County Assured Access Card, etc. *Resources: Maximize Existing Resources* *Determine $$ need & resources* *Action Steps:* • *Convene Healthcare Access Advisory Group* • *Clarify Board commitment* • *Coordinate department and community stakeholders for implementation* 2. Expand information/referral processes to all County Divisions/Departments *Resources: Maximize Existing Resources* *Action Steps: Public Health Department will take leadership role* 3. Goal for each applicant to have coaching resources available to help yield competed application *Resources: Maximize Existing Resources* *Staffing $$ Is Needed* *Action Steps: Public Health and E&EA will take leadership role* • *Increase E&EA resources and implement aggressive strategies to hire bi-lingual/cultural-specific staff* • *Partner and maximize outreach entry points:* ✓ *Apply for new outreach sites when funding is available* ✓ *Develop community agencies as outreach sites* ✓ *Support low-cost health care providers/systems (ex: Portico, Southside, St. Mary's, Westside) with outreach activities.* 5. If providers who offer sliding fees are present in the County, there is a need to validate level of poverty. *Resources: New $$ needed*

Recommendation Category	Short-Term Options (6 to 12 months)	Long-Term Options (1 to 5 years)
Expand Availability of Low-Cost Providers	1. Public Health to continue intake referral, health promotion (chronic care), clinic coordination. *Resources: Maximize Existing Resources* 2. Develop a coordinated strategy to work with low-cost health care providers to expand services in the County. *Resources: Maximize Existing Resources* *Action Steps: Public Health Department will take leadership role* • *Establish Healthcare Access Advisory Group* • *Determine and develop implementation options* • *Explore options to secure new $$ via joint efforts*	Implement New Initiatives as/if Board approved. 1. Develop "Portico" type health care access "pilot" program. *Resources: Maximize Existing Resources* *Staffing $$ is needed* *Develop New Funding Resources* *Action Steps:* • *Work with Portico and other community providers to gain buy-in* 2. Develop a consortium/brokers provider network for low cost providers +/or increase low cost providers in the county. *Resources: Maximize Existing Resources* *Develop new $$ Resources* *Action Steps:* • *Convene providers* • *Develop menu of services and associated sliding fees* • *Develop Health Care Access Card system based on Hennepin County Assured Access Model* 3. Assess feasibility for County based initiatives: *a. Develop a 24-hour Information/help line to assess need and refer for services* *b. Develop "Mobile Health Van" to increase outreach services* *Resources: Maximize Existing Resources* *Staffing $$ is needed* *Develop New Funding Resources*

HSAC Members Working on this Report

Health Care Access for the UnInsured and UnderInsured

JoAnn Johnson
Daniel Passe, Sr.
Terese Pilaczynski
Steve Cisneros
Cynthia Moore
Gretchen Meents
Lois Chambers
Kathryn Bique
Kathleen Glewwe
Sandy Hamel (Chair)
Gayle Moxness
Darin Haugland
Jean Brown
Donald L. Kuplic
Charlotte Shover
Sue Carey
Angelique Jespersen
Terrance F. McCall
Lyn Badje Gerdis
Janice Olson
Wade Branning